



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

October 26, 2006

FILE COPY

Doris Foruria, Administrator
The Cottages of Emmett
1920 Mayflower Wy
Meridian, ID 83709-8573

License #: RC-698

Dear Ms. Foruria:

On September 7, 2006, a state licensure survey was conducted at Cottages of Emmett, The. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact John Wingate, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

JOHN WINGATE, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

JW/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



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September 20, 2006

CERTIFIED MAIL #: 7003 0500 0003 1967 1275

Doris Foruria, Administrator
The Cottages of Emmett
1920 Mayflower Way
Meridian, ID 83709-8573

FILE COPY

Dear Ms. Foruria:

Based on the state licensure survey conducted by our staff at Cottages of Emmett, The on **September 7, 2006**, we have determined that the facility failed to protect residents from inadequate care. The facility failed to obtain emergency services for 3 of 7 sampled residents (#2, #5, and #7).

This core issue deficiency substantially limits the capacity of The Cottages of Emmett to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **October 22, 2006**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ♦ What date will the corrective action(s) be completed by?

Doris Foruria, Administrator
September 20, 2006
Page 2 of 2

Return the **signed** and **dated** Plan of Correction to us by **October 3, 2006**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**October 3, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 3, 2006**, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **October 7, 2006**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Cottages Of Emmett, The.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Lynne Denne, Program Manager, Regional Medicaid Services, Region III - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R698	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/07/2006
NAME OF PROVIDER OR SUPPLIER COTTAGES OF EMMETT, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 411 E 12TH ST EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the standard survey conducted at your residential care/assisted living facility on September 5, 2006. The surveyors conducting your survey were: John Wingate, RN. Team Coordinator Health Facility Surveyor Patrick Hendrickson, RN. Health Facility Surveyor Survey Definitions: NSA = Negotiated Service Agreement UAI = Uniform Assessment Instrument	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to obtain emergency services for 3 of 7 sampled, (Residents #2, #5 and #7). The findings include: The facility's "Operational Policies," reviewed on 9/6/06, stated residents who required immediate medical care for injuries would be transferred to the nearest medical center by a facility operated vehicle or ambulance. The facility's "Resident in-House Care Policy," reviewed on 9/6/06, stated in case of emergency, the resident would be transported to the local	R 008	<p>RECEIVED SEP 29 2006 FACILITY STANDARDS</p> <p><i>Policies & Procedure for Emergency Intervention Reviewed & Revised. See Attached Copies</i></p> <p><i>All future events will follow current Policy & Procedure</i></p> <p><i>All staff in-serviced on new forms, policies & procedures. (In-service scheduled for 10/6/2006)</i></p>	<p>10-1-06</p> <p>10/6/06</p>

Bureau of Facility Standards

Dina Fournia

TITLE *Administrator* (X6) DATE *9-30-06*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6889

H3U011

If continuation sheet 1 of 6

Bureau of Facility Standards

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R 008	<p>Continued From page 1</p> <p>emergency room either by a facility operated vehicle or ambulance.</p> <p>A. Resident #7's record, reviewed on 9/6/06, documented the resident was admitted on 4/14/06 with diagnoses which included Alzheimer's dementia.</p> <p>Resident #7's NSA dated 5/1/06, documented the resident needed staff assistance with emergency services.</p> <p>Review of the facility's "Incident/Accident Report" on 9/6/06 revealed on 5/22/06 at 5:00 p.m., the resident fell while walking to the dinner table and staff heard resident scream and found her lying on her back. There was no documented evidence that the facility called emergency services.</p> <p>Review of an untitled document dated 5/23/06, signed by the administrator, documented Resident #7 did not seem to be in a lot of pain, unless the leg was moved. The administrator further documented she thought the leg was broken, but waited until the son arrived to check on his mom before doing anything.</p> <p>Resident #7's hospital records from the emergency room dated 5/22/06 documented the resident fell, was complaining of right hip pain, and X-rays confirmed a fractured hip.</p> <p>On 9/6/06 at 12:05 p.m., the resident's family member confirmed the facility administrator called him on 5/22/06 around 5:15 p.m., and told him of the residents fall. He stated he went to the facility and took the resident to the emergency room.</p> <p>On 9/6/06 at 1:18 p.m., the administrator stated</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 2</p> <p>"I was unsure of our policy about what I should do so I waited for the resident's son to arrive." The administrator also confirmed that she failed to call 911, and failed to follow the facility's policies on emergency services.</p> <p>B. Resident #2's record, reviewed on 9/5/06, documented the resident was admitted on 2/28/06 with diagnoses which included cerebrovascular disease, arthritis, and osteoporosis.</p> <p>Resident #2's NSA dated 3/6/06, documented the resident needed total assistance with emergency services.</p> <p>An "Incident/Accident Report" dated 7/13/06 and timed at 3:30 a.m., stated staff found resident on the floor by her bed with bruising on right side of her face.</p> <p>The "Daily Log" was reviewed on 9/5/06. An entry dated 7/13/06 stated the resident complained of left foot pain. She had a large bruise on top of her foot, with swelling on the top and bottom.</p> <p>A "Hospice Note" dated 7/13/06, documented the resident was sitting in chair with her left leg elevated, and the top of the left foot had obvious swelling and bruising.</p> <p>An x-ray report from the hospital dated 7/13/06 at 3:56 p.m., documented the resident had fractured her left foot.</p> <p>On 9/6/06 at 9:30 a.m., the resident's family member confirmed the facility called her on the morning of 7/13/06 and told her of the resident's fall. The family member stated "when I went to the facility I found her face to be very bruised and</p>	R 008			

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R 008	<p>Continued From page 3</p> <p>she was complaining of left foot pain." The family member further stated they took the resident to the hospital later on that day.</p> <p>On 9/6/06 at 11:07 a.m., the administrator confirmed that facility policies were not followed for obtaining emergency care for Residents #7 and #2.</p> <p>C. Review of Resident #5's record on 9/6/06 revealed the resident was admitted on 11/2/03 with diagnoses which included Alzheimer's.</p> <p>The resident's record contained a UAI dated 4/25/06 that documented the resident needed total assistance to seek emergency help.</p> <p>On 9/6/06 the facility's "Incident/Accident Report" revealed a report dated and signed on 4/5/06 by the administrator. The report documented that on 4/4/06, at dinner time, the resident was "vomiting, very unsteady on her feet and not able to respond well" and that "staff put her to bed thinking she may have the flu." It further documented on 4/5/06 at 12:45 a.m., the resident was "very sick again" and "was very stiff and unable to stand or communicate clearly."</p> <p>Review of the facility's "Daily Log" on 9/6/06 revealed that on 4/4/06, the resident threw up two times during dinner and was jerking. It further stated the resident complained of chest and arm pain and was put to bed.</p> <p>Review of the hospitals emergency "History and Physical" revealed the resident arrived at the emergency room on 4/5/06 at 1:35 a.m., with complaints of nausea, vomiting, diarrhea and increased confusion that started at dinner time on 4/4/06.</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 4</p> <p>Review of the hospital's "Discharge Summary" dated 4/8/06 revealed the resident was admitted to the hospital on 4/5/06 with a diagnosis of mild dehydration, possible sepsis and possible aspiration pneumonia.</p> <p>On 9/6/06 at 1:50 p.m., the administrator confirmed that on 4/4/06 at dinner time the resident was "vomiting, very unsteady on her feet and not able to respond well." She further stated that staff put her to bed thinking she may have had the flu. She stated on 4/5/06 at 12:45 a.m. the resident again was "very sick", vomited, was very stiff and unable to stand or communicate clearly. She stated she was called about the resident's condition and "came in to assess the resident." She further stated the facility's nurse was not notified of the resident's condition.</p> <p>Review of the facility's "Operational Policies" on 9/6/06, revealed that residents who require immediate medical care for acute illness would be transferred to the nearest medical center.</p> <p>Review of the facility's "Resident in-House care policy" on 9/6/06 revealed that in case of illness, the resident would be seen by a physician.</p> <p>The facility failed to obtain prompt emergency services for Residents #2 and #7 when they had a fall with injury. Further, unlicensed staff assessed Residents health status, #2, #5 and #7's instead of notifying 911 as per policy. Further the facility allowed transportation of Residents #2 and #7 in a personal vehicles when the facility's policy states "In the case of an emergency, the resident will be transported to the local emergency room either by facility operated vehicle or ambulance as appropriate." This failure</p>	R 008	<p>Significant changes in condition and response identified in updated policy. See attached policies. Notification of facility nurse tool implemented for use with all contacts with facility nurse. See attached.</p> <p>Incident/Accident form reviewed + updated: Facility nurse will sign off & review these in addition to Facility administrator</p>	<p>10-1-06</p> <p>9/25/06</p> <p>9/25/06</p>

Bureau of Facility Standards

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R 008	Continued From page 5 resulted in inadequate care.	R 008			

Emergency Care & Notification Policy and Procedure

Policy: It is the policy of The Cottages of Emmett to act in the best interests of each resident in the event of an emergency or significant change in condition. These would include events/situations in which the resident is determined to be at risk due to illness and/or injury. Each resident has the right to timely access to medical services as they are required.

Procedure:

1. Staff shall assess the resident in the event of any significant event or injury for need for emergent services.
2. If such event results in life threatening bleeding, acute respiratory difficulty or any other immediately life threatening symptom(s), staff will immediately contact 911.
3. In all other events the facility administrator and/or facility nurse will be contacted to determine the next appropriate course of action.
4. If Hospice is involved, the Hospice agency will also be contacted. (If Hospice fails to respond in a timely manner, the facility administrator and/or facility nurse will determine the appropriate actions for treatment to proceed.)
5. 911 will be called if the injury/illness is such that facility staff or resident family may not safely transport the resident for additional health care services.
6. While awaiting Emergency Personnel, a staff member will remain with the resident and keep them safe and as comfortable as possible.
7. Another staff member shall get the appropriate transfer paperwork together to send with EMT personnel.
8. Family shall be notified of the situation and actions taken. (If a family member is designated as DPOA for the resident, they will be apprised of situation and be included in decisions for continued care as appropriate.)
9. The facility administrator or designee will follow up with additional calls and concerns for each event as needed.

Date Policy Implemented: October 1, 2006

Administrator Signature/Date: Dani Fournier

Cottages Owner/Management Signature/Date: [Signature]

Notification of Facility Nurse Policy and Procedure

Policy: It is the policy of The Cottages of Emmett for the facility nurse to be notified of significant changes in condition, medication changes and resident health concerns as they arise in a timely manner.

Procedure:

1. Staff shall call the facility nurse in the event of any significant change in condition, any unusual events or health concerns for all residents.
2. Staff will document notification of facility nurse on the established form for notification. Each notification will include the date/time of notification, nurse response/instructions and a signature from notifying staff member.
3. The facility nurse will review and initial each notification form when she/he is in the facility. Documentation in the nursing progress note will be made of her/his assessments and response as appropriate.
4. Staff will contact the facility nurse when new medication orders or changes in medication occur. They will stamp the order with the notification stamp and complete the appropriate information. The order will then be place in the nurse's folder for his/her signature.
5. The nurse is responsible to review and sign off on all medication orders. This is to be done within 48 hours of facility phone notification and phone delegation with the exception of weekends and holidays. The notification stamp should be completed by the staff at the time of contact via telephone. The nurse will sign off the stamp.
6. Consultation with facility administrator and care staff will be provided if is appropriate for each event, and documented accordingly in the nursing progress notes.

Date Policy Implemented: October 1 2006

Adminstrator Signature/Date: Doris Fournier

Cottages Owner/Management Signature/Date: Mark Maffitt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Coltapes of Emmett The	Physical Address	411 E. 12th Street	Phone Number	365-9490
Administrator	Doris Fobria	City	Emmett	ZIP Code	83617
Survey Team Leader	John Wingate RN	Survey Type	S/S	Survey Date	9-5-06

NON-CORE ISSUES

ITEM #	DATE	DESCRIPTION	DATE RESOLVED
1	16.03.22.21509	The administrator failed to notify Licensing and Survey Agency of reportable incidents.	9-6-06
2	16.03.22.30501	The facility nurse did not assess treatments re bed calls on residents #2, 3 and 6	9-21-06
3	16.03.22.30503	The facility nurse did not conduct a nursing assessment of the health status of residents by identifying symptoms of illness or physical changes	9-15-06
4	16.03.22.30506	The facility nurse failed to conduct an initial assessment on each resident that was found to have medications in their rooms. Rooms #1, 6, 7, 10, 11 and 15. However, rooms 1, 5, 9, 11 and 13. Also, Resident #4 was not assessed for self administration of subcutaneous insulin injections.	9-15-06
5	16.03.22.31001	Medications were dispensed from bulk containers.	10-6-06

Signature of Facility Representative

John Wingate

Response Required Date

10-5-06



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
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ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name <i>Cottage of Summertime</i>	Physical Address <i>411 E 12th Street</i>	Phone Number <i>365-9490</i>
Administrator <i>Doris Forsum</i>	City <i>Emmett</i>	ZIP Code <i>83617</i>
Survey Team Leader <i>John Wingebe RN</i>	Survey Type <i>S/S</i>	Survey Date <i>9-5-06</i>

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
6	16.03.22.310.01.A	Medications in room: Room 1 167 and 10 114.15 Homed Room 1's 9 11 and 13 while not kept in a locked area.	9-18-06
7	16.03.22.310.01.D	Residents were not observed by facility staff taking their medications.	9-15-06
8	16.03.22.310.01.C	The facility did not have a temperature log for refrigerated medications.	
9	16.03.22.310.01.E	Facility failed to document notification of the licensed professional nurse of a change in residents physical health.	9-15-06
10	16.03.22.711.13	The facility nurse did not document her assessment of residents' changes in health status.	9-15-06
11	16.02.22.730.01.F	2 of 2 employee records did not contain proof of current first aid certification.	9-28-06

Response Required Date
10-5-2006

Signature of Facility Representative
John F. ...

The Cottages of Emmett
411 E 12th Street
Emmett, ID 83617
208-365-9490 fax 208-365-1178

Item & Rule Number

Response

#1 – 16.03.22.215.09

Effective 9/06/06 all reportable incidents will be sent to Facility Standards within 24 hours.

#2 – 16.03.22.305.01

Bedrail Assessment Tool implemented and in place for all residents with bed rails as of 9/22/06. See attached Bed Rail Assessments

#3 – 16.03.22.305.03

Licensed nurse will conduct assessments of residents with illness or physical changes as appropriate. See revised Policy & Procedure for Notification of Licensed Nurse, report form and in-service. Effective 9/15/06

#4 – 16.03.22.305.06

Licensed nurse has reviewed the medications found in resident rooms and assessment tool was utilized for medications which remain in rooms. Tool for weekly room checks by staff implemented to check for medications in resident rooms which have been brought in without knowledge of nurse or other facility staff. See attached room check form. Assessment by Licensed Nurse of resident with injectable insulin completed and in resident record. Two residents currently have medications in their rooms. See In-service of 9/15/06

#5 – 16.03.22.310.01

Variance requested for bulk medications. Requested on 9/12/06 and again on 9/14/06.

#6 – 16.03.22.310.01

Lock box provided for all residents who have medications in their rooms. Currently two residents have medication in room. This is effective 9/18/06

#7 – 16.03.22.310.01

All residents will be observed by facility staff as they take their medications. No medications will be left unsupervised in a resident room. All staff in-serviced on 9/15/06 on medication pass policy & procedure, and on the 5 R's of medication pass. See Attached in-service form.

#8 – 16.03.22.310.01

A daily temperature log has been established for refrigerator temperature checks. This was implemented on 9/15/06. See attached log.

#9 – 16.03.22.711.08

All staff in-serviced on policy and procedure for notification of licensed nurse. Staff will notify RN accordingly and document per notification form. See attached P&P and notification form. In-serviced on 9/15/06.

#10 – 16.03.22.730.01

First aid certifications for employees are scheduled for 9/28/06.

BED RAIL ASSESSMENT TOOL

Hazel Mogenson
Resident Name

This resident is using a bed rail on their bed. The rail is ____/is not X a restraint.

It is X/is not ____ being used as a positioning device. Resident is able to safely get in and out of bed with bed rail in place.

Type of bed rail being used: ____ Full

____ $\frac{3}{4}$ Rail

X $\frac{1}{2}$ Rail X 2

____ $\frac{1}{4}$ Rail

Assessed By: Lerna Jaggard Date: 9/21/06
Licensed Nurse Signature

BED RAIL ASSESSMENT TOOL

Ima Huley
Resident Name

This resident is using a bed rail on their bed. The rail is ___/is not X a restraint.

It is X/is not ___ being used as a positioning device. Resident is able to safely get in and out of bed with bed rail in place.

Type of bed rail being used: ___ Full

___ $\frac{3}{4}$ Rail

X $\frac{1}{2}$ Rail X2

___ $\frac{1}{4}$ Rail

Assessed By: Lena Jaggar Date: 9/21/16
Licensed Nurse Signature

BED RAIL ASSESSMENT TOOL

Juan Higer
Resident Name

This resident is using a bed rail on their bed. The rail is ___/is not X a restraint.

It is X/is not ___ being used as a positioning device. Resident is able to safely get in and out of bed with bed rail in place.

Type of bed rail being used: ___ Full

___ $\frac{3}{4}$ Rail

X $\frac{1}{2}$ Rail X2

___ $\frac{1}{4}$ Rail

Assessed By: Lena Jaggard Date: 9/21/06
Licensed Nurse Signature

BED RAIL ASSESSMENT TOOL

Dena Guetschow
Resident Name

This resident is using a bed rail on their bed. The rail is ___/is not X a restraint.

It is X/is not ___ being used as a positioning device. Resident is able to safely get in and out of bed with bed rail in place.

Type of bed rail being used: ___ Full

___ $\frac{3}{4}$ Rail

X $\frac{1}{2}$ Rail X /

___ $\frac{1}{4}$ Rail

Assessed By: Lena Jaggart RN
Licensed Nurse Signature

Date: 9/21/06

9/21/06

1 $\frac{1}{2}$ rail used with low-bed. L. Jaggart RN

BED RAIL ASSESSMENT TOOL

Katie Kuntz
Resident Name

This resident is using a bed rail on their bed. The rail is ___/is not X a restraint.

It is X/is not ___ being used as a positioning device. Resident is able to safely get in and out of bed with bed rail in place.

Type of bed rail being used: ___ Full

___ $\frac{3}{4}$ Rail

X $\frac{1}{2}$ Rail X2

___ $\frac{1}{4}$ Rail

Assessed By: Leona Jaggard RN Date: 9/21/06
Licensed Nurse Signature

BED RAIL ASSESSMENT TOOL

Merrill Brown
Resident Name

This resident is using a bed rail on their bed. The rail is ___/is not X a restraint.

It is X/is not ___ being used as a positioning device. Resident is able to safely get in and out of bed with bed rail in place.

Type of bed rail being used: ___ Full

___ $\frac{3}{4}$ Rail

X $\frac{1}{2}$ Rail X2

___ $\frac{1}{4}$ Rail

Assessed By:

Lona Jaggard R
Licensed Nurse Signature

Date:

9/21/06

BED RAIL ASSESSMENT TOOL

Jaye Miller
Resident Name

This resident is using a bed rail on their bed. The rail is ____/is not X a restraint.

It is X/is not ____ being used as a positioning device. Resident is able to safely get in and out of bed with bed rail in place.

Type of bed rail being used: ____ Full

____ $\frac{3}{4}$ Rail

X $\frac{1}{2}$ Rail X 2

____ $\frac{1}{4}$ Rail

Assessed By:

Lerna Jaggard
Licensed Nurse Signature

Date: 9/21/06

The Cottages of Emmett

DATE: September 15, 2006

Trainer: Leona, R.N. *Leona Jaggartha*

Time: 10 am

Topic: Five R's for medication passing-review & delegation of med:
Additional Items Discussed - See Back

Attendance:

Signatures


Don Fournier ✓
Debra Blakely ✓
Collen Turca ✓
Susan Burbett ✓
Annaly Bailey ✓
Lauri R. King ✓
Marla R. Evans ✓
Phonda Newport ✓
Diana K. Cuevas ✓
Joel Van Arman ✓
Tawline Anderson ✓
Sandra Winter ✓
Martha Sorensen ✓
Siobhan ✓
Margie Russell ✓
Rena Ashton ✓


Basic First Aid
For First Aid Providers
in the Community and Workplace

Marla B. Evans

has successfully completed and competently performed the
required knowledge and skill objectives for a course in:
Pediatric First Aid Adult First Aid Universal First Aid

(Knowledge and skill not assessed if crossed out above)

 **American Safety & Health Institute**
an association of professional safety and health educators

 **St John**
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in health and safety at your doorstep

ASHI APPROVED CERTIFICATION CARD

Collin S. Garner
Authorized Instructor (Print Name)

Marla B. Evans
Holder's Signature

09/20/06 Sept 2008
Date Completed Renewal Date

(208) 321-4744 CPR CONN
Training Center Phone No. Training Center Note

Successful completion indicates card holder has met required knowledge and skill objectives of the curriculum to the satisfaction of an ASHI authorized instructor. Successful completion does not guarantee future performance, nor imply state certification or licensure. Program content is based upon recommendations of the 2005 National First Aid Science Advisory Board (Circulation ©2005) and other evidence-based treatment recommendations. Rate this program online at www.ashinstitute.org or call (800) 246-6101.

**THE COTTAGES OF EMMETT
INCIDENT/ACCIDENT REPORT**

Date of Report: _____ **Time/Date of Incident:** _____ / _____

Resident Name: _____ **Room:** _____

Family/Guardian Name/Date/Time Notified: _____

MD Notified: Y _____ N _____ **Date/Time:** _____

Where did the incident take place? _____

Was it witnessed and by whom? _____

If unwitnessed, was resident able to tell what happened? Y _____ N _____

Describe what happened:

Describe actions/measures taken (i.e. first aid, MD visit, ER, etc.)

Was resident sent to ER for treatment: Y _____ N _____

Signature of Person Completing Report/Date: _____

REPORTABLE EVENTS/INJURIES: Injury of unknown origin – not witnessed and resident unable to tell you what happened, Severe bruising of head, neck, trunk or any fingerprint bruising anywhere on body, Severe lacerations, Sprains, Fracture of bones, Elopement, Resident to resident altercations, Resident taken to ER, Death

Administrator Review of Event/Incident

Possible contributing factors:

New Medication(s) Yes _____ No _____

Possible side effects of any medications Yes _____ No _____

If so, which medications: _____

Doctor notified of side effects/incident: Yes _____ No _____ Date/Time: _____

Medication missed or refused: _____

Possible pain/incontinence/constipation: Yes _____ No _____ Last BM: _____

How long before incident last toileted or changed: _____

Any other factors that might contribute to pain issues: Yes _____ No _____

Other factors:

Environmental: _____

Too Much Noise/Light: _____

Too Much Stimulation: _____

Corrective Action Taken /Additional Comments: _____

Administrator Signature/Date: _____

Facility Nurse Signature/Date: _____

RN NOTIFICATION TOOL

Date/Time Notified: _____

Resident Name: _____

Information Reported to Nurse:

Nurse Response:

Signature of Person Reporting: _____

Administrator Initial Review: _____

RN Initial Review: _____

WEEKLY ROOM SWEEP FOR MEDS

[illegible]

DATE	REFRIGERATOR TEMPERATURES
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BED RAIL ASSESSMENT TOOL

Resident Name

This resident is using a bed rail on their bed. The rail is ____/is not ____ a restraint.

It is ____/is not ____ being used as a positioning device. Resident is able to safely get in and out of bed with bed rail in place.

Type of bed rail being used: ____ Full
____ $\frac{3}{4}$ Rail
____ $\frac{1}{2}$ Rail
____ $\frac{1}{4}$ Rail

Assessed By: _____ Date: _____
Licensed Nurse Signature



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name <i>Cottages of Emmett, The</i>	Physical Address <i>411 E. 12th Street</i>	Phone Number <i>365-9490</i>
Administrator <i>Doris Fauria</i>	City <i>Emmett</i>	ZIP Code <i>83617</i>
Survey Team Leader <i>John Wingate RN</i>	Survey Type <i>S/S</i>	Survey Date <i>9-5-06</i>

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
1	16.03.22.215.09	The administrator failed to notify Licensing and Survey Agency of reportable incidents.	10-19-06 <i>Jan</i>
2	16.03.22.305.01	The Facility nurse did not assess treatments ie bed rails on Residents #2, 3 and 6	10-19-06 <i>Jan</i>
3	16.03.22.305.03	The Facility nurse did not conduct a nursing assessment of the health status of residents by identifying symptoms of illness or physical changes	10-19-06 <i>Jan</i>
4	16.03.22.305.06	The Facility nurse failed to conduct an initial assessment on each resident that were found to have medications in their rooms. House 1; rooms #1, 6, 7, 10, 11 and 15. House 7; rooms 1, 5, 9, 11 and 13. Also Resident #4 was not assessed for self administration of subcutaneous insulin injections.	10-19-06 <i>Jan</i>
5	16.03.22.310.01	Medications were dispensed from bulk containers.	10-19-06 <i>Jan</i>

Response Required Date

10-5-06

Signature of Facility Representative

Doris Fauria



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Survey Team Leader <i>John Wingate RN</i>	Survey Type <i>S/S</i>	Survey Date <i>9-5-06</i>

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
6	16.03.22.310.01.A	Medications in rooms: Room 1 167 and 10 11 and 15 House 2: rooms 1, 5, 9, 11 and 13 were not kept in a locked area.	10-19-06 JWR
7	16.03.22.310.01.B	Residents were not observed by facility staff taking their medications.	10-19-06 JWR
8	16.03.22.310.01.C	The facility did not have a temperature log for refrigerated medications.	10-19-06 JWR
9	16.03.22.711.08.E	Facility failed to document notification of the licensed professional nurse of a change in resident's physical health.	10-19-06 JWR
10	16.03.22.711.13.F	The facility nurse did not document her assessment of resident's change in health status.	10-19-06 JWR
11	16.03.22.730.01.F	2 of 2 employee records did not contain proof of current first aid certification.	10-19-06 JWR

Response Required Date

10-5-2006

Signature of Facility Representative

Doris Foruria